# NEW JERSEY NATIONAL GUARD YOUTH CAMP
# VOLUNTEER APPLICATION

## APPLICATION DEADLINE 31 May 2005

## PLEASE CIRCLE THE POSITION YOU ARE APPLYING FOR:

**SENIOR COUNSELOR- AGES 18 YEARS & OLDER**

**JUNIOR COUNSELOR – AGES 15-17 YEARS**

**SAFETY/SECURITY – AGES 18 YEARS & OLDER**

**ARTS & CRAFTS - AGES 18 YEARS & OLDER**

**SPORTS - AGES 18 YEARS & OLDER**

**BEACH - AGES 18 YEARS & OLDER**

**ADMINISTRATIVE - AGES 18 YEARS & OLDER**

**PUBLIC AFFAIRS - AGES 18 YEARS & OLDER**

**MEDICAL- AGES 18 YEARS & OLDER (MUST HAVE LPN/RN CERTIFICATION)**

**COOKS - AGES 18 YEARS & OLDER**

**TRANSPORTATION - AGES 18 YEARS & OLDER**

**LOGISTICS - AGES 18 YEARS & OLDER**

**Please list 2nd choice in the event the position you are applying for is full**

_____

**Job descriptions follow on the next page**

**Are you available full time _____ part time_____. If part time what are the days and hours you are available _____**

_____

**NAME: _____**

**(PLEASE PRINT)**

# JOB DESCRIPTIONS

**SENIOR COUNSELOR** – Must be available for the entire week of camp. Have overall responsibility for the supervision, safety, and motivation of each camper assigned and works to build Espirt de Corps among campers. Monitors all camper activities to insure health, welfare and safety issues are addressed.

**JUNIOR COUNSELOR** – Assist the Senior Counselors in all of the above duties and to set an example for all campers. Show care and respect for all campers and staff. Participate in all programs and activities with the campers.

**SAFETY/SECURITY** – Perform security for the camp. Work one of three shifts to ensure the safety and well being of the campers. Duties include keeping sign in & out rosters, bed checks, headcount, and safety checks. Does not require overnight stays.

**ARTS & CRAFTS** – Assist the Arts & Crafts director in the operation of the activity. To include daily set-up of activity, clean up and helping campers with their daily projects. Does not require overnight stays.

**SPORTS** – Assist the Sports director in the operation of all sports activities, which includes soccer, volleyball, flag football, and the sports Olympics. Does not require overnight stays

**BEACH**- Assist the Beach director in the operation of all beach activities. Must be able to swim, and perform life saving measures. Perform the duties of a lifeguard. Does not require over night stays.

**ADMINISTRATIVE** – Assist the Administrative director in operation of an Administrative Center. Duties include setting up and maintaining the in-processing of all campers, volunteers, and counselors. Maintenance of daily reports, creation of camp certificates, and campers folders. Assist with the set up and break down of the admin center.

**PUBLIC AFFAIRS** – Assist the Public Affairs director in the areas of preparing daily newsletter, photos both digital, 35mm and video. Maintain daily log of all photos and work orders completed. Requires some knowledge of photography and or journalism.

**MEDICAL** – Requires certification as a Doctor, RN, LPN, or EMT. Provide care to all campers, counselors, staff should the need arrive.

**LOGISTICS** – Provide direct support to the logistics director. Duties include set up and clean up of barracks, maintain & deliver daily supplies used in operation of youth camp. Set up and breakdown of special activity areas.

**COOKS** - Prepare all meals for the youth camp. Set up, serve and clean up of the food service line and the dining facility.

**TRANSPORTATION** – Provide all transportation in support of camp activities on and off post. Bus license required for driving of buses. Work under the direction of the logistics director.

Please list any special talents or certifications you may have. _____

# ALL VOLUNTEERS UNDER THE AGE OF 18 MUST COMPLETE

**PART A MEDICAL HEALTH , HISTORY AND EXAMINATION FORM.**

**PART B IMMUNIZATION RECORD ( To be completed by Physician)**

**PERMISSION TO MEDICATE FORM ( If taking Medication both non and prescription medication) (Turn in at in Processing)**

**STANDING ORDERS for OVER-THE –COUNTER MEDICATIONS**

**MEDICAL EMERGENCY AUTHORIZATION (Must be notarized)**

# VOLUNTEER APPLICATION
# NEW JERSEY NATIONAL GUARD YOUTH CAMP
# 17-23 July 2005

**NAME: _____**

**SSN#: _____**

**ADDRESS: _____**

**CITY: _____STATE: _____ ZIP:_____**

**HOME PHONE: (area code) _____ _____**

**AGE: _____ DATE OF BIRTH: _____/_____/_____**

**T- SHIRT SIZE (ADULT) S M L XL XXL XXXL**

**EMERGENCY CONTACT NAME: _____**
**Emergency Phone # (Day) ( ) _____(Evening): ( ) _____**

**What is your Affiliation with the NJ National Guard (Circle one)?**
**Member / Family Member / Friend of Member / Other: _____**

**Air Guard Army Guard Unit: _____**
**(circle one)**
**I am a full-time employee of the National Guard ____yes _____no**

**My Status is : ___AGR ____Fed Tech _____State Emp _____M-DAY Soldier _____AGN ____ARNG**

**Full time Employees of DMAVA (ARNG, ANG, or State) Must submit a copy of your Official Leave OPM Form 71 or equivalent for the period covering New Jersey Youth Camp. Leave Form attached _____yes ____no.**

**Do you have camp experience? YES NO**
**If yes, explain: _____**

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**List your areas of expertise/experience/skills:**
**1. _____**
**2. _____**
**3. _____**

**Why do you wish to volunteer?**

**Name:** _____

**Do you have children who will be either attending the camp or volunteering?**
**Attending _____ Volunteering _____**
**Names:** _____

**Will you need lodging? YES NO**

**Email address:** _____

**PARENTAL AGREEMENT IF UNDER 18 YRS OF AGE:**

**I _____, parent/guardian of _____**

**_____, grant permission for my child to participate in the NJNG Youth Camp as a junior volunteer.**

_____ _____
**Signature** **Relationship**

**Please return completed application with all appropriate documents to:**

**New Jersey National Guard Youth Camp**
**ATTN: CW4 Ralph W Cwieka, J 1**
**3650 SAYLORS POND ROAD**
**FORT DIX, NEW JERSEY 08640-760**
**For further information, please contact CW4 Ralph W. Cwieka at 609-562-0668**
**Or email:** ralph.cwieka@nj.ngb.army.mil
**You will be notified by mail when to report for camp when you receive your conformation packet.**

**NEW JERSEY NATIONAL GUARD YOUTH CAMP HEALTH HISTORY AND EXAMINATION FORM**

**PART A TO BE COMPLETED BY THE PARENT/GUARDIAN**

VOLUNTEER NAME:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

DATE OF BIRTH: ____/_____/_____ PLACE OF BIRTH: _____

Parent/Guardian Name: _____ Relationship: _____

Telephone # Home: ( ) _____Work ( ) _____

**Name, address and phone number of nearest next of kin (other than Parent/Guardian):**

Name: _____ Address:_____

City: _____State: _____ Zip: _____

Phone: ( ) _____

INSURANCE CARRIER: _____

Policy # _____

| HEALTH HISTORY (COMPLETED BY PARENT/GUARDIAN) | YES | NO |
|---|---|---|
| 1. Is the child under a physician's care now? | ___ | ___ |
| if yes, explain _____ | | |
| 2. Has this child ever been medically advised not to participate in any kind of sports? | ___ | ___ |
| 3. Is this child medically excused from physical education at the present? | ___ | ___ |
| 3. Has He/She… | | |
| a. Ever been unconscious after an injury? | ___ | ___ |
| b. Ever had a fracture or dislocation? | ___ | ___ |
| c. Ever had any surgery? | ___ | ___ |
| d. Within the last year, had to stay in a hospital overnight? | ___ | ___ |
| e. Ever experienced frequent chest pains or palpitations? | ___ | ___ |
| f. Ever experienced high blood pressure? | ___ | ___ |

PART A CONTINUED:

5. Does this child. . . YES NO

   a. Have a history of fainting with exercise? ___ ___

   b. Have a history of tiredness/fatigue? ___ ___

   c. Take any medications every day? ___ ___

   d. Have any allergies, including bee stings, hives, asthma? ___ ___

   e. Have a family history of sudden unexplained death under age 40? ___ ___

6. Do you have any worries about his/her health or think that there may be any reason why he/she cannot participate in sports? ___ ___

7. List any malfunctions or absence of a paired organ (eyes, kidneys, testes, etc).

8. Please list and explain any illness, injury, surgery, allergies and /or medications since his/her last physical.

9. Has your child been designated as a "special needs" child in his/her school district or defined as having "Attention Deficit Disorder". ___ ___

**PLEASE EXPLAIN ALL YES ANSWERS:**

**Signature of Parent** _____ **Date** _____

PART B

TO BE COMPLETED BY PHYSICIAN

## IMMUNIZATION RECORD

| **Name of Child (Last, First, MI)** | **Birth Date (Mo, Day, Yr)** / / | **Sex** ☐ **Male** ☐ **Female** |
|---|---|---|
| **PARENT/ GUARDIAN** | **Name** | **Phone ( )** |
| | **Address** | |

| **VACCINE TYPE** | **DISEASE DATE** | **1ST DOSE Mo/Day/Yr** | **2nd DOSE Mo/Day/Yr** | **3rd DOSE Mo/Day/Yr** | **4th DOSE Mo/Day/Yr** | **5th DOSE Mo/Day/Yr** | **6th DOSE Mo/Day/Yr** |
|---|---|---|---|---|---|---|---|
| **Diptheria, Tetanus, Pertussis - DPT** *if DT or TD, indicate in corner box | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Oral Polio Vaccine (OPV)** if Salk Vaccine, Indicate (IPV) in corner | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **MMR (Measles, Mumps & Rubella)** | | | | | | | |
| **Measles** | | | | | Measles or Serology | Date | Titer |
| **Rubella** | | | | | Measles or Serology | Date | Titer |
| **Mumps** | | | | | Measles or Serology | Date | Titer |
| **Other (Specify)** | | | | | | | |

| DT Requires valid medical exemption | Provisional admission attached ☐ Date Granted: | Medical exemption attached ☐ | Religious exemption attached ☐ |
|---|---|---|---|

| TB Screening (Mantoux Test) | Date | Date | Date |
|---|---|---|---|
| Tested | _____ | _____ | _____ |
| Read | _____ | _____ | _____ |
| Result (MM) | _____ | _____ | _____ |

| Chest X-Ray Date | Result Normal | Abnormal |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Therapy
Case ☐ Reactor ☐
Date Started _____
Date Completed _____

## HEALTH CARE RECOMMENDATION BY LICENSED PHYSICIAN

** I have examined the above camp applicant **within the past two (2) years**
Date Examined: _____/_____/_____

In my opinion, the above applicant ____is ____is not fit to participate in an active camp program.

The applicant is under the care of a physician for the following condition: _____
_____

Current Treatment (Include current medications, attached medication form): _____
_____

Explanation of any reported loss of consciousness, convulsion or concussion: _____
_____

Does applicant have epilepsy? Yes _____ No _____ Diabetes? Yes _____ No _____

Any treatment to be continued at camp_____
_____

Recommendations and Restrictions while at camp _____

PHYSICIAN SIGNATURE: _____ DATE: ___/_____/____

Printed Name: _____ Phone #: ( ) _____ - _____

**STANDING ORDERS**

**for**

**OVER – THE – COUNTER MEDICATIONS**

**For NJ National Guard Youth Camp Campers and Staff**

**NAME:** _____

**ALLERGIES:** _____

| | |
|---|---|
| **BENADRYL** | 12.5 mg 1-2 tabs PO q6 hours, as needed. |
| **TUSSAFED** | Ex.Srup 1 Tsp. PO q6 hours as needed |
| **TYLENOL** | 325 mg 1-2 tabs PO q4 hours PRN headache, temp >101, generalized pain. |
| **MOTRIN** | 200 mg 1-2 tabs PO q6 hours PRN headache, temp >101, generalized pain. |
| **MYLANTA** | over 48 pounds: 1-2 tabs (or 1-2 tsp) PO q1 hour PRN upset stomach, gas. DO NOT EXCEED 6 tablets (or 6tsps) per 24 hours. |
| **TUMS ULTRA** | 1-2 tabs PO q1 hour PRN upset stomach, gas. DO NOT EXCEED 6 tablets per 24 hours. |
| **1%HYRDRO-CORTISONE CREAM** | Apply to affected area sparingly BID PRN itch. |
| **PEPTO-BISMAL** | 1-2 tabs PO PRN upset stomach |

Physician Signature: _____ Date: _____

Print: _____

Legal Guardian Signature: _____Date: _____

Print: _____

**Dear Parent or Guardian,**

1. No medication, prescription or non-prescription drugs (cough drops, aspirin, Tylenol, etc.) will be given to a child by the nurse unless it is received in the original container and accompanied by a written physicians **and** parental/guardian request.
2. All medications are to be held in the nurse's office with the parent/guardian assuming the responsibility for delivering such and picking up unused amounts when no longer needed.
3. Prescription medication **must** be in the original pharmacy-labeled container.
4. Opportunities must be provided for child/parent/physician/nurse communications.
5. The physician must be consulted by the nurse whenever necessary to discuss medications being given to anyone under the age of 18 including long-term use and possible abuse of any over-the counter medications.
6. **No volunteer under the age of 18** will be allowed to medicate him/herself during the camp.

# PERMISSION TO MEDICATE FORM

An authorization form is required to be signed by the physician and the parent/guardian of any child or volunteer under the age of 18 who must receive medication during camp.

NAME OF VOLUNTEER: _____

NAME OF PHYSICIAN: _____

NAME OF MEDICATION: _____

_____

TIMES AND DOSAGE TO BE TAKEN: _____

_____

LENGTH OF TIME MEDICATION WILL BE REQUIRED: _____

| _____ | _____ | _____ |
|---|---|---|
| DATE | NAME OF PHYSICIAN | SIGNATURE OF PHYSICIAN |

| _____ | _____ | _____ |
|---|---|---|
| DATE | NAME OF PARENT | SIGNATURE OF PARENT |

**THIS FORM MUST BE RETURNED TO THE NURSE DURING IN-PROCESSING IF YOUR CHILD REQUIRES MEDICATION WHILE ATTENDING CAMP. DO NOT RETURN WITH MAIN APPLICATION.**

**MEDICAL EMERGENCY AUTHORIZATION**
**THIS FORM MUST BE COMPLETED OR CHILD WILL NOT BE ABLE TO ATTEND CAMP.**
**THIS FORM MUST BE NOTARIZED !!!!!!!!**

In case of sudden illness or an accident to the below named participant, requiring immediate treatment or surgery while participating in the NJ National Guard Youth Camp Program, I authorize the Primary Staff or Medical Staff to take such action as deemed appropriate to protect the health and physical well-being of my child. This authority extends to any physician(s) and /or surgeons(s) selected by the Primary Staff to perform medical and/or surgical procedures including examination and tests necessary to preserve the life and well-being of my child.

All efforts will be made to contact the parent(s) or guardian(s) in case of an emergency.

**Name of child:** _____

**Parent or Guardian:** _____

_____

(Parent or Guardian Signature)

**Address**: _____

**City, State, Zip**: _____

**Phone Number**: _____

**Work Number**: _____

**Cell Phone/Pager Number**: _____

**Doctors Name:** _____

**Doctor Phone Number**: _____

Notary: _____

Date/Stamp/Seal

*******THE ABOVE MEDICAL EMERGENCY AUTHORIZATION STARTS ON THE FIRST DAY OF CAMP ENTRY OR 17 July 2005 (which ever comes first) AND EXPIRES ON 23 July 2005 UPON THE COMPLETION OF CAMP*******

# VOLUNTEER STAFF HEALTH RECORD 18 YEARS OLD AND OVER

NAME: _____ Sex: _____ Date of Birth: __/__/__
Address: _____
City: _____ State: _____ Zip Code: _____

PERSON TO CONTACT IN CASE OF EMERGENCY:
Name: _____
Relationship: _____
Address: _____
City: _____ State: ____ Zip Code: _____
Phone Numbers: ___ - ___ - ____ **(W)** ___ - ___ - ____ **(H)**

****IMPORTANT: This form must be filled out completely, signed and returned with your application.**

HEALTH HISTORY: **All** questions must be answered

Are you in good health? Yes No
If no, explain: _____

Do you suffer from allergies or do you require medication? Yes No
If yes, please state type of allergy and/or medication: _____

Do you suffer from any illness, disease, physical disorder or other condition that may limit your participation? Yes No
If yes, please explain: _____

Name, address and telephone # of physician: _____
_____
Area code:( ) _____ - _____

Name and address of Health Insurance: _____
_____
Policy #: _____

***** I understand that the NJ National Guard Summer Youth Camp is sponsored by the NJ NG Family Foundation, Inc. which is an independent corporation with no legal connection to the NJ National Guard. I hereby voluntarily waive any claim against the New Jersey National Guard, the Department of Military and Veterans Affairs or the United States of America for any or all causes which may arise in connection with my participation in the New Jersey National Guard Summer Youth Camp.***

Signature: _____ Date: __/__/__

# Volunteer Certification Form

I, the undersigned, do hereby certify under penalty of perjury, that I have not been convicted in New Jersey or any other state or jurisdiction, of any crime or disorderly persons offense involving sexual offenses, child molestation, endangering the welfare of children or incompetence.

**I, grant permission** to the NJ National Guard Family Foundation, Inc. to conduct a background investigation to verify that I do not have a criminal record. I understand that this information will be kept confidential and that it is required to provide protection and a safe environment for the children.

Name: _____
SSN: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Signature: _____

Date: _____

**IDENTIFICATION CARD INFORMATION**
(PLEASE PRINT)

**VOLUNTEERS NAME:**
**_____**

**DATE OF BIRTH: _____**

**EYE COLOR: _____ HAIR COLOR: _____**

**HEIGHT: _____FT. _____ INCHES**